Chapter

CUSHIONED PATIENT, TURMOILED THERAPIST: AWARENESS AND USE OF COUNTERTRANSFERENCE AND ENACTMENT AS PART OF THE THERAPEUTIC PROCESS

ABSTRACT

The therapeutic relationship can be difficult to navigate particularly when communication is projected through the *unsaid* or unconscious processes in the room. The therapist is tasked with being able to detect the unsaid through implicit or explicit countertransference. How the therapist deciphers the communication and works with the experienced countertransference impacts on the therapy. The therapy can either flourish or terminate prematurely. In presenting a case study of such an experience, I explore countertransference, enactment and the therapeutic relationship with a patient who struggled to engage with her own needs. I also explore my struggle of not being able to communicate my understanding of her need to her.

Keywords: Therapy, therapeutic process, countertransference, enactment

INTRODUCTION

The purpose of psychotherapy[1] is to improve an individual's life functioning and satisfaction, and the value of psychotherapy is measured by this improvement (Norcross 2000). Psychotherapy can be effective in alleviating psychological symptoms and effecting character change (Fosshage 2011, Lipsey and Wilson 1993, Seligman 2003, Wampold 2000). The therapeutic relationship comprises of two parties—a therapist and a patient. For therapists to be effective agents of change, they must be both physically and mentally fit. To enable this, therapists engage in physical self-care (e.g., exercise and diet) and reflect on their patterns through journaling, attending supervision, consulting with other professionals and participating in personal therapy. These activities contribute to the maintenance of a healthy level of functioning (Fosshage 2011, Jennings and Skovholt 1999, Mahoney 1997, Norcross 2000, Seligman 2003). A healthy level of functioning enables less entanglement within the patient's story and also allows for change to occur (Fosshage 2011, Norcross 2000).

Research has explored the role of the therapist and the role of therapy in the personal transformation of the patient (Fosshage 2011, Lipsey and Wilson 1993, Seligman 2003, Wampold 2000), but less focus has been directed at exploring what happens in the exchange of the *unsaid* between the two parties and its contribution to the treatment process (Macran, Stiles and Smith 1999). Being aware of the *unsaid* or latent messages between patient and therapist takes skill—often a skill honed with experience—to understand what is being communicated through the therapeutic process (Orange 2002), thus making the therapeutic relationship itself essential to treatment. Given this, supportive practices such as supervision, personal therapy, peer supervision and/or peer discussions can assist therapists to be mindful of what is happening in the therapeutic process.

Personal therapy, that is, the intervention in which the psychotherapist is a patient, has a significant impact on therapists' *perceptions* of their own professional effectiveness (Skolveldt and Ronnestad 1995). Benefits of personal therapy include increased empathy, heightened self-awareness, increased understanding and tolerance of patients, and awareness of countertransference and transference processes (Fosshage 2011, MacDevitt 1987, Macran et al. 1999, Norcross, Strausser-Kirkland and Missar 1988, Wiseman and Shefler 2001, Zachrisson 2009).

[1] The terms 'psychotherapy' and 'therapy' are used interchangeably, with the latter term used as a shortened version of the former.

The focus of this chapter is the treatment of a patient who was also a psychotherapist. The chapter tracks her process of negotiating life, love and work. I highlight the therapeutic process between us, the impact of the manifest and latent content on both of us, and the importance of boundaries, countertransference feelings and enactments in forging a strong enough therapeutic relationship. This was a relationship able to withstand a premature termination, a return to therapy, a physical illness, personal transformation and mutual influence. Withstanding the onslaught of transference expectations is a process with which many psychoanalytic psychotherapists engage. Having the knowledge of how to do this is attained with professional experience and is not necessarily taught. In presenting this case, I explore how uncertainty and ambivalence in both the patient and the therapist could have ruined the therapeutic relationship; I show how it created space for trust and connection. I argue for the use of countertransference feelings and experiences, particularly in the form of measured countertransference disclosure that facilitates greater relational engagement with the patient.

THE THERAPEUTIC RELATIONSHIP

Freud's focus on the relationship between therapist and patient peaked in the 1930s with the advent of ego-psychology (Hatcher 2010). The interest in relational processes in therapy led to the psychoanalytic therapist supporting the notion of a split in the ego to allow for the development of an observing, rational part of the ego and the irrational forces existing in the patient's transference (Hatcher 2010). In the 1950s the term 'therapeutic alliance' (Zetzel 1956) was coined, and it referred to the conscious, rational and collaborative agreement between patient and therapist (Walters 2009, Zachrisson 2009). The term also referred to the nature of the therapeutic work and how both patient and therapist could proceed with it (Gilbert and Orlans 2011). The 1960s brought shifts in thinking about therapeutic work. The therapeutic alliance was split into a tripartite model, which consisted of the working alliance, the transference-countertransference relationship and the real relationship (Gelso and Hayes 1998). These facets have a strong psychoanalytic conceptualisation; however, the alliance was not seen as curative in itself. Cure was the domain of therapeutic techniques or interventions, and the relationship was meant to facilitate the conditions for interventions to bring about the cure (Safran and Muran 2000).

The therapeutic alliance can be articulated as three dichotomies or conflicts (Kivlighan and Shaughnessy 2000, Stiles et al. 2004): (1) the conflict between the rational (reasonable) relationship and the irrational (transferential) relationship through which the therapeutic alliance aims for "an alignment" (MacKewn 1997, p. 87) between the rational (reasonable) sides of both therapist and patient; here, the therapeutic alliance provides an anchor for the patient when the work becomes overwhelming, such as during analysis of transference or in the surfacing of difficult emotions; (2) a conflict between relationship and technical factors, wherein work on the relationship is not understood as an intervention; and finally, (3) a conflict between facilitative and curative factors of therapy, where establishing the alliance between therapist and patient allows for techniques and interventions but is not necessarily therapeutic (Mitchell 1998, Safran and Muran 2000). The conflicts that arise in the therapeutic relationship can be negotiated and worked through depending on the quality of the alliance.

The quality of the therapeutic alliance depends on the interaction between the patient and therapist. Four emergent alliance patterns may be encountered (Stevens et al. 2007, Stiles et al. 2004). The first pattern is a stable alliance, characterised by little change in strength of the alliance throughout the therapy; the second is a linear growth pattern, where there is an increasing strength in the alliance (Campiao 2012); the third relates to a U-shaped alliance, in which a high-low-high pattern emerges, because a strong alliance exists at the beginning and end of therapy but is weak in the middle; the fourth is a V-shaped pattern wherein the middle of the therapy process is marred by ruptures and repairs that strain the alliance, yet enough of a connection still exists for repair (Campiao 2012, Kivlighan and Shaughnessy 2004, Stiles et al. 2004).

Therapist and patient negotiate the therapeutic alliance both consciously and unconsciously. This involves a process of understanding the conflicts that may be at play in the room and is achieved through deciphering whether the conflicts are based on the rational (real) or irrational (transferential) part of the relationship. Relational psychoanalytic theory maintains that therapeutic ruptures are co-created by both the therapist and patient; this implies that the therapist needs to understand her part in the relationship and in the rupture and repair process (Aron 1996, Mitchell 1997, Ringstrom 2010, Safran and Muran 2000, Stolorow, Atwood and Orange 2002). The therapeutic alliance is influenced by experiences of both past and present interactions with others, on the part of both therapist and patient. Past experiences are reignited in the therapy situation through transference on the patient's side; and, on the

therapist's side, the therapist experiences countertransference reactions in relation to the patient, both in the room and/or in her personal and private spaces.

To understand the interactional process of what might occur between patient and therapist, elaboration of transference and countertransference is required because they feed into how the therapist and patient experience each other in the room (Gold and Stricker 2011, Haskayne et al. 2014, Kivlighan and Shaughnessy 2004, Safran and Muran 2000, Stiles et al. 2004).

Transference and Countertransference

The term transference was coined by Freud (1905, p. 116), when he spoke of and defined transference as:

> new editions of facsimiles of the impulses and fantasies which are aroused and made conscious during the progress of the analysis; but they have this peculiarity, which is characteristic for their species, that they replace some earlier person by the person of the physician. To put it another way: a whole series of psychological experiences are revived, not as belonging to the past, but as applying to the person of the physician at the present moment.

Freud (1912) believed that the goal of transference in therapy is for the patient to find the link between the current symptoms or behaviours and past experiences. Furthermore, in uncovering the link between symptoms and past experiences, the therapist analyses the emotional reactions evoked in the patient. Freud's idea of transference is linked to his idea of *transference neurosis*, where a patient's earlier or past experiences and relationships act as contributors that trigger the unconscious feelings and reactions associated with past figures that are then aimed at the therapist in the therapeutic setting. Moreover, Freud cautioned that the transference could turn the therapist-patient relationship into an emotional one, often marred by feelings linked to fantasies, particularly those from the first proper fantasised relationship of the patient's childhood (Sandler et al. 1992).

Others, like Alexander and French (1946), stress the irrational repetition of stereotyped reactions and patterns of behaviours that have not been adjusted to the current or present situation.

With varying definitions of transference having been formulated, an appropriate position to adopt is that transference is only a part of the relationship between therapist and patient and is not the 'total' relationship. It is the part of the relationship that is often irrational and not justifiable within the objective situation (Bateman and Holmes 1995, Osbourne 2011):

> Transference could therefore be defined as a specific illusion which develops in regard to the other person, one which, unbeknown to the subject, represents, in some of its features, a repetition of a relationship towards an important figure in the person's past or an externalisation of an internal object relationship (Sandler et al. 1992, p. 58).

Freud (1910) used the term *countertransference* to denote the therapist's transference of unconscious past experiences onto the patient. Freud did not write much about countertransference, but other theorists (Gabbard 2009, Lemma 2003, Osbourne 2011) have interpreted his work and provided a more comprehensive understanding of the concept. Seemingly, Freud argued that *countertransference* occurred when the patient triggers unresolved conflicts within the therapist, and these conflicts surface when the therapist is unable to properly deal with those characteristics of the patient that represent a problematic figure from her own past, implying that the therapist needed more therapy (Osbourne 2011). Freud elaborated on how the 'counter' of countertransference represented both transference of emotions onto the patient, as well as a reaction to the patient's transference (Osbourne 2011).

The concept of countertransference, like transference, has evolved over the last century. The classical view of countertransference dominated psychoanalytic circles until psychoanalysts questioned Freud's conceptualisation.

In 1946, Klein introduced the concept of projective identification—an intrapsychic process and defence mechanism, wherein unacceptable parts of the self are split off and projected onto the object in an attempt to get control over and dominate the object (Klein 1946/1975, Segal 1986). In its original form, the concept was unrelated to countertransference. Later, however, the concept was given a central role in the understanding of the analytic relationship (elaborated on in patient-induced countertransference).

The contemporary definition of countertransference includes all the therapists' feelings and reactions to the patient (Heimann 1950, Kernberg 1965). This definition is broader than the classical definition and includes realistic, as well as distorted and conflict-based reactions to the patient. In

addition, this definition considers countertransference to be both beneficial and harmful, whereas the classical definition considers it essentially negative.

Heimann (1950) argued that countertransference reactions can be used to better understand the patient, in so far as therapists are aware of their countertransference feelings. From this viewpoint, countertransference provides a unique opportunity to investigate the patient's unconscious conflicts and defences (Heimann 1950). The therapist's emotional reactions towards the patient was considered an important tool in analytic work (Heimann 1950). To echo Heimann's work, Little (1951) wrote, "If we can make the right use of countertransference may we not find that we have yet another extremely valuable, if not indispensable tool?" (p. 33). Sullivan (1953) recognised that the key to using countertransference beneficially is for therapists to be aware of their own reactions and then use them judiciously. These positions extended Freud's idea that all individuals, by means of their unconscious, have a tool for the interpretation of others' unconscious expressions (Falchi and Nawal 2009).

Contemporary thinking of countertransference differs from Freud's classical model in that it puts forward a direct connection between countertransference and its use as a tool or technique in therapy. Heimann (1950) extended Freud's concept of the therapist's evenly suspended or hovering attention to include not only the patient's experiences, but also the therapist's own experiences and reactions. The argument is that therapists, through experiencing their own reactions with a patient, are more able to follow the patient's affective shifts, unconscious fantasies and somatic movements, thus gaining insight into the unconscious latent material and unspoken messages (Falchi and Nawal 2009, Gelso and Carter 1985, 1994; Ivey 1999; Safran and Muran 2000). This broad view conceptualises countertransference predominantly as a reaction to the patient's unconscious conflicts as they unfold in the process and is less about the internal unprocessed conflicts and personality traits of the therapist.

In this way, countertransference is 'created' by the patient and is part of the patient's personality. Given that the patient is creating 'something' in the room with the therapist, a warning to therapists is that they should not become co-actors in the patient's drama and should also avoid exploiting the relationship for their own needs at the expense of the patient (Heimann 1950, Little 1951, Racker 2007). Ivey (1999) clarifies this:

> Although transference and countertransference are conceptually distinct, in reality they are fused components of an intersubjective field in

> which patients unconsciously dramatise their transference illusions and compel therapists to relive elements of the patients' childhood histories and internal object relations by means of countertransference evocations. (p. 63)

The broad view of countertransference is used in most contemporary theories and analytic settings because many therapists seem to accept that countertransference is a complex unconscious phenomenon, a joint creation, co-constructed by therapist and patient in the communicative field of the therapy process (Falchi and Nawal 2009, Hoffman 2006, Racker 2007, Walters 2009).

An Integrated Experience of Countertransference

A third definition of countertransference has evolved too. This seems to be a combination of the classical and broad views. The third definition, which I would like to term an *integrated experience*, is conceptualised as the "internal and external reactions in which unresolved conflicts of the therapist, usually but not always unconscious, are implicated" (Gelso and Hayes 2002, p. 269). Also, these reactions can be used beneficially "if the therapist successfully understands his or her reactions and uses them to help understand the patient" (Gelso and Hayes 2002, p. 269). This definition is similar to the classical view in that countertransference consists of therapist reactions that are irrational rather than reality-based (Gelso and Carter 1985, 1994; Gelso and Hayes 1998, Safran and Muran 2000). However, it differs in terms from the classical definition by being similar to the broad view that countertransference reactions can be used beneficially as a tool in therapy.

Therapists inevitably will experience their own personal challenges and changes. In the therapeutic profession, as they develop, they would be required to take these experiences to their own therapy, but those concerns remain private and should not be shared with their patients. When blurred lines exist between the origins of patient-induced and therapist-based countertransference, more damage than good may occur. Thus, to assist therapists on their developmental journey in the field, various theorists (Gelso and Hayes 1998, Hayes 1995, Ivey 1999, Racker 2007, Reich 1951) have attempted to categorise or organise countertransference reactions.

Annie Reich (1951) was one of the first analysts to attempt to distinguish between countertransference responses. She argued for the need to distinguish

between two types of responses: (1) where the therapist acts out some unconscious need or fantasy with a patient (which Heimann and Freud warned against), and (2) where the therapist defends against some unconscious need or fantasy (Ivey 1999, Reich 1951).

TYPES OF COUNTERTRANSFERENCE

Therapist-Induced Countertransference

Countertransference can be as present as transference in a psychoanalytic psychotherapy process. An essential differentiation is to understand whether the countertransference is predominantly patient-induced or therapist-based. Subjective or therapist-induced countertransference refers to the therapist's own unresolved neurotic difficulties, (re)activated in the therapeutic setting, which could influence or disrupt the analytic attitude and effectiveness of the therapy, either temporarily or chronically (Falchi and Nawal 2009). This can give rise to resistances or 'blind spots' (Freud 1910), or an unconscious need to use a patient for the gratification of the therapist's own neurotic needs (Heimann 1950, Little 1951, Racker 2007, Reich 1951).

Within therapist-induced countertransference, two broad categories may be further distinguished: situational countertransference and characterological (personality) countertransference. Situational countertransference refers to the event of the therapist being unusually vulnerable to respond to a patient in atypical ways because of transient life situations, which impacts on the ability to listen and intervene effectively (Brandchaft 1991, Heimann 1950, Little 1951, Racker 2007, Waska 2008). Characterological countertransference occurs when the therapist *persistently* responds to patients in a manner determined by personality characteristics disproportionate with the therapeutic attitude, irrespective of situational factors. Therapist-induced countertransference derives from situational factors, personality factors or some combination of these (Brandchaft 1991, Brandchaft and Stolorow 1990, Busch 2006, Ivey 1999, Racker 2007, Waska 2008).

Patient-Induced Countertransference

Objective or patient-induced countertransference refers to the countertransference of the therapist that is based primarily on the unconscious

identification with some projected part of the patient's internal world, and it occurs after some unconscious interactional pressure from the patient in the form of subtle (or gross) verbal or behavioural cues (Busch 2006, Gabbard 1995, Ivey 1999, Racker 2007, Waska 2008). This includes projective identification and role-responsiveness.

Projective Identification

Projective identification, a concept first proposed by Melanie Klein (1946), was conceptualised as separate from countertransference; more recently, however, it has found its place in relation to countertransference experiences (Segal 1986). According to Klein (1946), projective identification involves an intrapsychic fantasy through which the projector rids herself of an anxiety-provoking part of the self (a self or object-representation) by depositing it onto the projectee, and this occurs together with an interpersonal process in which the projector induces emotional reactions in the projectee that correspond to the projected component (Klein 1946, Segal 1986, Waska 2008).

The concept of projective identification has been used and adjusted by many Kleinian theorists or object relational theorists (Busch 2006, Racker 2007, Sandler 1976). Racker (2007) distinguishes between two forms of identification, depending on whether the projected component comprises an internal self-representation, in which case it is called a *concordant identification*, or whether it comprises an internal object-representation, in which case it is referred to as a *complementary identification*. Projective identification seems to be a mechanism used by a patient to communicate unconscious material non-verbally by inducing a certain kind of affect shift, somatic feeling or thought in the therapist (Bateman and Holmes 1995, Busch 2006, Racker 2007, Sandler et al. 1992, Waska 2008). It is considered to be a patient-induced countertransference because it stems from the patient's internal representations of objects, which is projected onto the therapist who then enacts (countertransference) in a particular way specific to the patient, induced by the patient's projections.

Role-Responsiveness

Another form of patient-induced countertransference is what Sandler (1976) termed role-responsiveness. In this case, transference is not simply a fantasy or perception of the therapist; it also involves an attempt by the patient to manipulate the therapist into actualising a relationship based on

complementary roles derived from the patient's experience in her family of origin (Racker 2007, Sandler 1976).

The two forms of patient-induced countertransference are useful when applied to dynamics of transference with patients. One question to consider is: Are therapists in the room with patients more prone to experience some form of projective identification, and/or are they designated a particular role by the patient, thus being compelled to behave in the way the patient needs them to behave? Furthermore, therapists may have their own personal experiences to contend with and this may cloud their judgment in managing the co-constructed communication in the web of countertransference experiences. Notably, countertransference is a compromise formation between personal tendencies and the role unconsciously imposed upon therapists by their patients. Thus, the therapeutic setting is an interactional field of mutual influence wherein both participants unconsciously affect each other while discovering idiomatic aspects of their intrapsychic lives (Stolorow et al. 2002, Racker 2007, Busch 2006). Ivey (1999) succinctly summarises this: "Transference and countertransference refers not simply to internal states or intrapsychic configurations, but also to relational transactions carrying unconscious contributions, from both patient and therapist" (p. 350).

COUNTERTRANSFERENCE IN PSYCHOANALYTIC PSYCHOTHERAPY

Countertransference is not to be understood in isolation from transference, therapeutic interventions and other psychoanalytic processes as all of these are considered important in the therapeutic process or relationship between therapist and patient (Hill and Knox 2009). The psychoanalytic framework in therapeutic treatment is the space to explore countertransference (Safran and Muran 2000). Countertransference can therefore be "something [that] takes place in the analyst threatening to bring him or her out of analytic position" (Zachrisson 2009, p. 178). The "something" could refer to a feeling of irritation, anxiety or loneliness. It may also refer to tendencies to be too pleasing toward a patient or not sticking to the frame or agreements as expected (Campiao 2012).

The therapist-as-person has to meet the patient with a particular mentality and way of behaving—this is the analytic attitude (Zachrisson 2009). Zachrisson (2009) argues that therapists need to give attention to what happens

to themselves in the therapy process. Countertransference reactions will allow them to recognise when they fall out of the analytic position or when they deviate from the frame. To maintain the frame, the analytic attitude accompanies the therapy process and includes skills such as emotional neutrality, empathic listening and evenly suspended attention (Bion 1962, Haskayne et al. 2014, Hoffman 2006, Reich 1951, Wachtel 2008). This requires a balanced presence wherein the distance/closeness and emotional temperature has been negotiated in relation to the patient.

Therapists also find their own personal style within the analytic frame. The personal style allows the therapy situation to work. Zachrisson (2009, p. 179) provides a list of dimensions or conditions for therapists to heed:

- Maintaining respectful distance: not too distant, or reserved and arrogant; not too close, making it [too] intimate;
- Keeping an open mind for everything that is there, whatever it may be;
- Avoiding moralistic judgments, avoiding 'knowing better,' avoiding fussiness;
- Using tact, responsibility and politeness combined with seriousness, impartiality and sobriety;
- Focussing on both or all sides of the patient's internal and external conflicts, as well as considering their own influence on the patient;
- Avoiding either/or thinking.

When a therapist bears these conditions in mind, a sense of being a therapist and a personal style of working with patients may be developed. Therapists need to develop and discipline their own way of working to form their own personal styles.

Further, questions may arise about behaviours, thoughts, fantasies or pictures that can unexpectedly appear to therapists (Ivey 1999, Lemma 2003, Racker 2007, Zachrisson 2009). Also, subtle or overt mood shifts may occur; therapists may be more or less alert, bored or drowsy, and these may be signs of possible unconscious reactions, either as a reaction to the patient or because of their own issues (Wampold 2012).

Thus, many behaviours, mood shifts, thoughts, experiences and emotions can be classified as countertransference reactions, but these all occur in relation to the patient. Zachrisson (2009) argues that focus should not be on the overt countertransference reactions on which the therapist stumbles but rather on the more subtle unnoticeable deviations in method and attitude.

These deviations can be easily explained in one instance, yet in the next, inadequate or unfortunate analytic action may end up compromising the treatment (Walters 2009, Zachrisson 2009).

Signs of exaggerated countertransference reactions toward patients can be identified in the therapist worrying about a patient and the session long after it has ended, being preoccupied with the patient between sessions, engaging in arguments with the patient, or feeling hurt by criticism or contempt (Hill and Knox 2009, Ivey 1999, Zacchrison 2009). Outside awareness, these countertransference experiences can be detrimental.

Lack of awareness of personal issues and 'blind spots' can result in a host of reactions, both internal and behavioural, that adversely impacts the therapist-patient relationship, but also determines the likelihood that the patient will benefit from therapy (Safran and Muran 2000, Wachtel 2008). Therapists, who might be blocked in their empathic ability, may filter out relevant patient material that is too painful to hear, or they might inadvertently minimise patients' struggles in an attempt to avoid their own pain (Greenson 1967, Wachtel 2008).

Generally, countertransference reactions, namely, mistakes, dreams, unclear emotions and slips of tongue, appear as signs of unconscious feelings and conflicts within the therapist. Therapists could also find themselves being uncertain of the patient's feelings, struggling to feel empathic with the patient, and overidentifying with the patient. Therefore, therapists should know themselves well enough to easily recognise changes in their ways of being with patients. This would make therapists more aware of countertransference reactions and (re)enactments.

COUNTERTRANSFERENCE AWARENESS AND ENACTMENT

Maroda (1998) describes a countertransference enactment as:

> an affectively driven repetition of converging emotional scenarios from the patient's and the analyst's lives. It is not merely an affectively driven set of behaviours, it is necessarily a repetition of past events that have been buried in the unconscious due to associated unmanageable or unwanted emotion. Enactment thus involves mutual stimulations of repressed affective experience, ideally with the patient taking the lead. (p. 124)

As with transference enactments, the therapist needs to be aware of the transference in order to notice the enactment. The same is true for countertransference, as it also becomes conscious only after an unconscious acting-out (enactment) with patients (Shumsky and Orange 2007). Renik (1993) explains this theoretical position:

> As it stands, our theory of technique indicates that an analyst should strive to minimize his *[sic]* countertransference enactments in order to maximize his countertransference awareness. However, if countertransference enactment is a prerequisite for countertransference awareness, then elimination of countertransference enactment is not only unattainable as a practical technical goal, but it is misconceived even as a technical ideal toward which the analyst should strive. (p. 139)

As these extracts illustrate, therapists need to engage in enactments in order to become aware of the countertransference experience. Therapists need to be aware of what is being stirred up in them when they are working with a patient. The literature indicates that countertransference enactments are not always negative for they could have a positive effect on the therapy, but only if the therapist makes correct use of it. Countertransference enactments occur when "an attempt to actualise a transference fantasy elicits a countertransference reaction" (Gabbard 1995, p. 479). Therapists are tasked with the responsibility of understanding the contents of the transference fantasy and how they need to respond to it. In being able to understand this, enactments could be avoided. If it is not possible for the therapist to understand what the transference need is, the countertransference enactment serves as the key to provide clarity on the situation.

Because sparse literature exists on countertransference *awareness* and its centrality within the therapeutic context or the 'in-the-room' experience, I will try to add to this body of knowledge by delving into my countertransference experience with a particular patient. This involves how I experienced, made sense of and managed the countertransference reactions in relation to this patient. The discussion hereafter will focus on these understandings of countertransference, with the aim being to present countertransference awareness as a tangible process. In other words, I aim to illustrate how the unsaid of countertransference can be explored and articulated with therapeutic goals in mind. The case material thereby provides insights that can enable discussion and classification of countertransference within the project of advancing understanding of this highly complex construct (Gelo and Hayes

1995, Ivey 1999, Kasper, Hill and Kivlighan 2008, Lambert 2007, Racker 2007).

The case is of Gina who I had treated for about two years. This was a complex process because the therapy process began when I was still finding my feet as a therapist and I had not clearly and maturely developed my therapeutic style within the psychoanalytic framework. The initial phase with Gina was filled with transference expectations, which I struggled to meet; and this resulted in a process difficult for Gina to negotiate with me, leading to a premature termination.

CASE MATERIAL: THE CASE OF GINA

Gina[2] is a 29 year old, single, unmarried female psychologist in Johannesburg, South Africa. She works at a government (public) hospital. She originates from a coastal South African town where she resided with her family. After completing her internship, she relocated to Johannesburg to complete a compulsory community service year to meet the requirements for registration as a clinical psychologist with the country's professional body. She originally attended therapy while completing the community service year. Her reason for initiating therapy was reported to be "*like the right thing to do*" while she worked with her assigned hospital patients.

Gina's history is that of a typically parentified child. She is the second oldest of four children. She reported having sensed the family's expectation that she would keep the household going, while her siblings "*could live their lives."* She considered her eldest brother not to have any obligations to the family, perceiving him to do whatever he wanted to. The two younger siblings were sent to a boarding school, thus she was the only child at the parental home and was expected to continue living with her parents. She was provided with the funds to begin her studies at university, but her parents could not afford to sustain her through the years. She therefore had to work, saving enough funds to pay the university fees. She worked as an au pair in the United States and the Netherlands. She seemed to forge relationships with her host families while working for them and had fond memories of her time overseas. When she returned to South Africa, she completed her studies in psychology and reported that she always felt her relationships were never 'normal'. She felt that the way she related to people was "off" and that she

[2] Gina is a pseudonym used to protect the identity of the patient.

found herself becoming more and more annoyed with her hospital patients. During the initial therapy process, which lasted about 7 months, Gina struggled to connect to her own intimacy and dependency needs. The therapy was initially difficult because every caring intervention I made was met with suspicion and guilt. She explained she did not need someone to feel 'sorry' for her, and when I showed concern and understanding, she felt as though I was mocking her. Nevertheless, I experienced moments when she allowed me access to her vulnerabilities and she accepted my care. These moments, however, were few, and she felt terribly ashamed afterwards, resorting to cancelling the subsequent sessions as a means of preserving her sense of self and dignity.

Gina's account of her life revealed she experienced her mother as very punitive and harsh, as well as non-responsive to her needs. She described her mother as not being able to respond to her when she tried to engage her; instead her mother told her to go to church or pray about her difficulties because that was where Gina was told she could find the answers. Her father was described as caring, soft and "a bit of a walk over" as her mother dominated him "completely". This was Gina's expectation of me: I would dominate her. When I did not play into the punitive role, I was met with suspicion and hostility, being told that I was behaving like her father and that that was not "okay" because, as a woman, I should behave as her mother would. Gina admitted that she had struggled to relate to women and found interactions with men far easier. Interactions with women were strained as she felt that she needed to always take responsibility for the interaction, as she had done with her mother.

Given that Gina was trained as a psychologist, she knew much about therapeutic processes and often commented on or identified the interventions I used. Often, she countered my reflections by telling me that she thought the textbook would have provided a different response to mine but she can accept my attempt. I suspected that this was her way of trying to help me understand the inferior feelings she had about herself. Another difficulty in the initial therapy process was that I struggled to connect with her. I often felt frustrated and rejected by her, as though she did not need me but still came to therapy, perhaps out of obligation, because it was 'the right thing to do'. When I tried to use my countertransference feelings in the room, Gina felt as though I was taking up her space with my feelings and rejected my attempts at understanding her. Eventually, Gina decided that, after her community service year, she would not continue with therapy with me as she would not be treating patients, and therefore did not consider the need for her own therapy. I

reflected to her that it must be very difficult for her to feel as though she always had to be the responsible one. I added that I could imagine the amount of strain she takes in making sure that she meets the needs of others but I wonder who takes care of her needs and provides her with the support she needs. This led to Gina becoming teary, and for the first time since I had been treating her, she cried in therapy. She thereafter spoke of all the times she felt misunderstood and unheard in her familial and intimate relationships. Although I felt the relief that came with the emotional release, I wondered what the consequences would be for our relationship as she was not comfortable with showing any vulnerability.

The following week, she cancelled the session, due to her family visiting her. Two weeks later, in the next session, she told me she thought she was ready to terminate therapy as she felt that she had dealt with her issues. She reasoned that her parents had come to visit her, and she found herself dealing with her mother in a much better way in the previous week. I believed that she was not ready for termination so I was able to say to her that I did not think that this was the most appropriate time to end. I also expressed that I wondered if her wish to terminate therapy was related to dynamics in the previous session. She denied that the decision to terminate was linked to feeling vulnerable and feeling resentment toward me for bringing out her emotional and tearful response. I offered my thoughts on the matter again: I did not think that she should terminate but it was her decision. I also pointed out that leaving therapy would mean she is playing into her patterns of leaving a situation when things are tough or when they do not work in her favour. She responded by saying that she will take her chances but she thinks she is fine. At the end of the session, which turned out to be our termination session, while she was leaving, she asked if the door was open, should she wish, to return in the future. I responded affirmatively and assured her that I would not hold her decisions against her and that she could return at any time. After the session, I felt confused by what had happened but also angered by the premature termination. I felt as though she left without any discussion or explanation. I was also angered by the position she allocated to me, that is, to either ‘force’ for her to stay in therapy (mother’s position) or to let her go and live her life (father’s position). Over the next few months, I often remembered Gina, wondering about how she could be fairing. I wondered if she would return to therapy, and if we would ever have the opportunity to discuss what happened between us.

Exactly one year later, I received a call from Gina, enquiring if she could return to therapy. I responded that a time slot had become available that week

but I had relocated my practice to my home. She expressed surprise, but she agreed to attend the session. Our second attempt at therapy started well. She spoke of our past sessions and about how she remembered me, stating that she had had conversations with me in her mind. I experienced a sense that she needed to make sure that the space was safe to return to and that she needed to reassure me of my influence on her. Gina admitted that perhaps she was angry at me for making her feel things that she was not ready to feel or admit to, and she needed to "*get out, so leaving you was the only thing I could think to do"*. We were able to speak about the abrupt ending and she wondered if it affected me in the way it did her. She hoped she had not disappointed me but she took a chance in returning because she saw how different I was in comparison to her mother and that she had been unfairly painting me with the brush of past experiences.

I was very happy to see Gina again and relieved that we had the chance to close the previous chapter and start a new one. The second bout of therapy with Gina started when she was working at a local tertiary institution and was unhappy there. We spent the first few months trying to establish what the unhappiness was about. Gina had a history of trying out new experiences but not necessarily committing to them. Often, the challenge in starting something new motivated her, but once it became routine, she fought against it or escaped. This was a concern given our first therapy process. I raised this, and she responded, "*You're not a shiny new toy or challenge, so I don't feel like this is going to be something I run from again.*" Gina reported that she was still struggling to rely on people and she experienced difficulties with expressing her needs to anyone. Even though therapy focused on her career choices and questioning about what she would like to do going forwards, Gina also spoke of having a lump in her groin that first appeared in 2007, to which she did not pay attention. The lump appeared and then disappeared; this concerned her but she was too afraid to have it examined because she did not want to find out if it was cancerous. About two months into our second therapy process, the lump reappeared and it was still there two months thereafter. When the lump reappeared we discussed at length her options and fears around the lump. She eventually went to a physician and was referred to an oncologist who diagnosed her with lymphoma, and he required her to go for stage testing. She was uncertain of what to expect. She did, however, do what was needed and succeeded in navigating the initial phases of the diagnosis and treatment without telling anyone other than me. She could not fathom having anyone else involved in the process of attending chemotherapy sessions. As an attempt to reach out to someone, she said very solemnly: "*I need someone who*

would be impartial and objective, would you be able to accompany me to my first chemo session?" This raised a remarkable thought process for me after the session; but in the moment when she asked this, my whole being gave a resounding "*yes, of course, I will be there for you.*" Even though I knew she would not have me attend the session with her, her asking this of me meant a lot to both of us. The meaning was that she was able to ask the question and admit to needing someone to accompany her through the process.

The next 9 months felt like a rebirthing process for both of us. She was navigating various processes of being diagnosed with cancer and needing treatment every 21 days. She started to reflect on her life, trying to find a reason for why this was happening. This included thoughts of her past behaviours having brought on the cancer as a punishment for those deeds. There was no family history of cancer; she was only 31 years old; she could not understand why this was happening to her. Gina disclosed her illness to her brother, who arranged for one of his friends to attend the first chemotherapy session with her. She wanted me there too, but she also did not want to hold me to accompanying her because she expected me to be working and therefore did not want to disturb me. So, she had her brother's friend attend the session with her as he was emotionally removed from her. She explained that having someone emotionally close to her at her treatment would have been too difficult for her to handle as she is not used to being vulnerable in the presence of people close to her. Still, she displayed an inherent need to present a brave face for her family and not let on to anyone how severely the diagnosis had affected her. She tried to be strong for her siblings because she did not want them to feel pity for her, She often said, "I don't want them to look at me with those eyes, the cancer pity eyes." Eventually, she softened and opened up to me about her experiences and what it was like to attend chemotherapy. She recalled this: "*the chemo smell*, *the loss of taste, following a particular diet and not being able to drink alcohol, I feel like I'm sick, like there is something wrong with me and I'm not the same.*" I felt more connected to Gina through this process, to the point where it felt as though we had been going through the treatment together.

Gina could not find any joy or feeling in the world; everything was difficult and was too much effort. If people tried to interact with her, they were met with skepticism and negativity. She tried to isolate herself but those friends who knew about the illness did not allow this. She eventually disclosed to her mother, who reacted as Gina expected. Her mother told her to go to church and pray for help. Gina was angry with herself for hoping for a

different response from her mother and started to rely on her siblings, friends and therapy for support.

One day, she had heard on the news that a local television presenter had died in a car accident. This seemed to upset Gina tremendously because "*he chose to die*", she said. She could not understand "*why he had chosen to die when he had such a nice life from what we could see.*" I reflected to her how angry she seemed about him choosing to die, yet she, who is alive, is choosing not to live. She was able to hear this reflection and thought about it for a while. She said she could see how she has chosen to "die" in the way that the actor did. This seemed to spark something for Gina, because from that point, she used that experience to measure her level of engagement with life.

While Gina was gaining a new lease on life, I was experiencing my own personal turmoil of loss and grief, with periods of anger, depression and acceptance. I struggled to understand why she had been diagnosed with cancer, and why I was incredibly angry about the diagnosis and the treatment process. When she arrived, once, feeling as though she wanted to stop the treatment, I said, "*We've been through so much with this diagnosis, and we only have two more chemo sessions to get through.*" For Gina, these words made her feel that I was accompanying her through the process. Consequently, she said, "*I have never felt this held and supported, as though I've had a pillow under my head, because you've held me through this process. I don't think I would have gotten through it if it wasn't for this space and for you being you. It's like you are with me.*"

I considered this to be a beautiful and profound acknowledgement. Little did she know that over the preceding 3 months, I experienced repeated periods of questioning whether or not I had cancer or an undetectable illness. I submitted myself to many medical and blood tests to rule out any illness; I also changed my diet and exercise routine, all in an attempt to remain healthy and to (irrationally) prevent cancer in some way. While I carried much of the anxiety of being diagnosed with cancer and enacted this outside of the therapy room, I was able to connect to the scared part in her. The enactment allowed us to connect to each other because I allowed myself to feel her very fears and she concurrently allowed herself to feel my care. Gina completed her chemotherapy and felt relieved at the prospect of not returning to the medical center where she was receiving treatment and "inhumanely treated by the doctor and nurses who forced me to accept the diagnosis". Gina was able to look back on her experience and find some solace in her ability to have survived the treatment process and ask her friends and siblings for assistance

when she needed it. The rest of her time in her therapy focused on her finding meaning in her life post cancer diagnosis and treatment.

MAKING SENSE OF EXPERIENCES

In recalling Gina's case, I am reminded about the importance for a therapist to be aware of the latent messages being exchanged between patient and therapist. To understand what is being communicated through the therapeutic relationship and process, I needed to be mindful of the parts of both therapist and patient being played out in the process (Orange 2002). Winnicott (1974) refers to a truly transformative therapeutic process only being possible when the focus goes beyond just the transference and countertransference in the room. The therapy process should allow for the both patient and therapist to push boundaries in each other, so that the patient can feel that the therapist is able to survive the attempt at therapeutic destruction (Winnicott 1974).

At first, Gina and I did not have a strong therapeutic alliance because neither of us felt a rhythm or strong connection to each other. The first attempt at therapy with Gina was a struggle for both of us; I tried to reach her in a particular manner and perhaps she was not ready for that kind of intervention. Every attempt I made to show care and concern was met with hostility and anger, which could be seen as her attempt at destruction (Winnicott 1974). Working through the initial transference situation with Gina, where I was expected to be just like her mother, was difficult for me because she strongly expected me to behave in a manner that was not me. She wanted me to be emotionally cold, distant and unaware of her emotional needs. Attempts by the patient to evoke specific responses from the therapist often indicates the patient's need to allocate a specific transference identity or role to the therapist, resulting in the unconsciously reliving of the disturbed object relationship from the past (Sandler 1976). The transference was clear in my interaction with Gina, yet difficult for me to analyse. When exploring patient-induced countertransference, the therapist must apply the experience to the dynamics of transference with the patient.

In the situation of a strong compulsion to behave in a manner that is inconsistent with the self of the therapist, a process of complimentary identification is considered to be occurring (Racker 2007). This is a process that can be explored and discussed with the patient, but the patient's reaction

to this material is unpredictable and something a therapist may wish to avoid as a means of protecting the relationship. However, it can then result in some form of an enactment. With Gina, however, towards the end of our first therapeutic interaction, I started to rebel against the complimentary identification process and tried to interpret her transference. She was not ready to hear or engage with the interpretation; this process in and of itself could be considered as an enactment on my part. I may have been actively trying to show her or provide her with a new experience but she rejected this different approach. She could not accept being vulnerable at the time and could not see my concern for her for what it was, that is, genuine concern and care, so she terminated the therapy. Possibly, my letting go of her was a form of complimentary identification enactment, where I did behave like the internal object representation she needed me to be—distant, but appreciative of her feelings, as her father had been. Further, given that I consider therapy as a co-constructed process, I needed to take into account my own personal process at that time. I was not feeling heard in my own personal life and with Gina not hearing me in the sessions, I added to the co-constructed communication in the web of countertransference experiences. I was forceful in trying to get my point across and less intent on her staying and working with me.

Of note is that countertransference is a compromise between personal tendencies and the unconscious role imposed upon therapists by patients. Therefore, therapists must always bear in mind that therapy is an interactional field with mutual influence, where both the patient and the therapist unconsciously affect each other while discovering aspects of their intrapsychic lives (Busch 2006, Racker 2007, Stolorow et al. 2002). It took Gina a year to recover from the initial process with me and then to become more aware of her own needs. She returned to therapy and was able to work through her needs and accept vulnerability. There was a different interaction the second time around. I felt she was able to trust me with more of her self and her needs. She was able to become vulnerable and form a healthy dependence on me, without viewing her dependence as a problematic way of being in the world. While Gina was struggling with her diagnosis of cancer, she became concerned with herself and her progress, sidelining the pattern in which she needed to be concerned about me and how I was dealing with her diagnosis.

In the dominant pattern as shown in her process with her mother, she was always concerned about how her mother would deal with information thus Gina could not explore her own feelings about the situation. I interpreted this as a sign of progression in our process, where she could separate me out from

the internal object representation and see me for who I was and what I meant to her. She was no longer painting me with the same brush of past experiences.

I was, however, struck by my behaviours in the first 3 months following her diagnosis. I submitted myself to physical check-ups and blood tests, changed my diet and adjusted my physical exercise routine, all in an attempt to detect or prevent cancer. In relating these behaviours to my supervisor and therapist, I realised I was holding on to a part of Gina that she was not ready to cope with just yet: the part of her *self* that was struggling to accept the diagnosis of cancer. A form of concordant identification (Racker 2007) occurred, where Gina was projecting a part of her self onto me. When I realised what was happening in our process, I held on to that part of her, despite nudges from my supervisor to feed back to Gina her difficulty in accepting the diagnosis. I held that off and engaged in an enactment process through colluding with her in those moments of utter disbelief, anger and sadness around the diagnosis. Perhaps, I did not feel that I could put her through facing the cancer as the doctors and nurses did at the treatment centre. I wanted to create a space for her to explore what she wanted without having her choice to engage being removed. By the time we could both deal with the diagnosis, name it eventually, talk about its appearance in her life and examine its impact, she had already received four chemotherapy sessions and she was able to access the feelings of anger, sadness and disappointment about the cancer.

Countertransference enactments become conscious only after an unconscious acting-out has occurred (Shumsky and Orange 2007). Contemporary thinking around enactments argue that therapists have to engage in enactments to be aware of what the countertransference is about. Therapists need to be aware of what is being stirred up in them when they are present with a patient (Maroda 1998l, Shumsky and Orange 2007).

Although classical psychoanalytic theory argues for the negative influence of enactments on the therapy process (Renik 1993), contemporary literature argues against the negative influence (Maroda 1998, Ehrenberg 1992). Countertransference reactions and enactments are not always negative; they can impact positively on the therapy if utilised correctly. When therapists understand that countertransference enactments are "an attempt to actualise a transference fantasy" (Gabbard 1995, p. 479) and when therapists take the responsibility of understanding the transference fantasy and the need of the patient, the negative impact of an enactment becomes demystified.

CONCLUSION

Therapists' awareness of themselves and their own needs is as important as that of the patient and the patient's needs. Therapists need to be aware of physical, emotional and cognitive changes in themselves as these changes could form part of a countertransference experience that impacts on the therapy in positive or negative ways. It has long been thought that countertransference and countertransference enactments are unnecessary evils in a therapy process and that they should be banished and taken care of by the therapist. However, contemporary writings argue for an integration of countertransference as a useful tool in therapy, with enactments often serving as necessary evils that provide insights after the fact. Being aware of countertransference reactions allows therapists to better recognise when they deviate from the therapeutic frame or their usual ways of engaging with patients. Being able to hold onto the therapeutic frame and sense of self facilitates therapy as it allows for emotional neutrality, empathic listening and evenly suspended attention (Bion 1962, Haskayne et al. 2014, Hoffman 2006, Reich 1951, Wachtel 2008).

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